AG Radiology Imaging Center
www.agradiology.com

601 Park Grove
Katy, Texas 77450
Phone: (832) 321-3434
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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT IDENTIFYING INFORMATION:

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone #: _____-_____-_____ Cell Phone #: _____-_____-_____ Today's Date: _____

I hereby authorize AG Radiology Imaging Center to release my medical records to:

Full Name: _____
Mailing Address: _____
Phone #: _____-_____-_____ Fax Number: _____-_____-_____

Specific Information to be disclosed:

☐ Report(s) Procedure(s)/Dates _____
_____

☐ CD(s) or Film(s) Procedure(s)/Dates _____
_____

This health information is needed for:

☐ Continuing Medical Care ☐ Personal Use
☐ Legal Reasons ☐ Other _____
☐ Insurance

_____
Patient/Recipients Name (Print) Signature Date:

_____
Witness

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FOR OFFICE USE ONLY

PICK UP/MAIL OUT DATE: _____ **ISSUED BY: _____** **ID CHECKED: _____**